Kansas Department of Health & Environment
Bureau of Local & Rural Health

Annual Report
Kansas State Loan Repayment Program

Obligated Health Professional _____

Social Security Number _____-_____-_____

Practice Site _____

_____

_____

_____

_____	_____	_____
Site Contact Person	Phone	Email

Indicate the weekly hours worked per week of the above named provider. Only include the actual work hours; do not include travel or on-call time. If the provider practices at more than one location, please indicate the work schedule for each location.

_____

_____

I certify that the above named health professional provided services to patients at the practice site named above on a full-time basis (40 hours per week), at least 45 weeks per year and at least 32 hours per week (21 hours for OB/GYN physicians, providers of geriatric services, pediatric dentists, certified nurse midwives and behavioral and mental health providers), for the previous twelve months from _____, 20____ through _____, 20____.

Signature of Obligated Health Professional _____ Date _____

Printed name of Obligated Health Professional _____

Signature of Authorized Site Representative _____ Date _____

Printed name of Authorized Site Representative _____

Title _____

Please return to: Barbara Huske
Kansas Department of Health and Environment
Kansas State Loan Repayment Program
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365